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Clinical guidelines: quantity without quality

The potential of guidelines to produce notable improvements in the quality of health care has been clearly demonstrated in well conducted trials,[1] and is accepted by many potential users.[2-5] A huge increase in the development and dissemination of guidelines over the past few years is suggested by the many guidelines retrieved in a survey from Finland published in this issue of *Quality in Health Care*.[6] As with other healthcare interventions, however, there is concern that what can be achieved in the controlled setting of a trial will not be achieved when the intervention is used in routine practice. This problem is particularly prominent in the case of interventions which are aimed at influencing clinical behaviour. The difficulties of extrapolating results from subjects involved in a trial of treatment to a particular patient in clinical practice pale into insignificance beside those of extrapolating results to clinicians from other clinicians involved in a trial of a particular guideline, for a specific condition, with selected patients in a given healthcare system. This does not mean that it cannot or should not be done, and it is patently unnecessary to conduct a randomised controlled trial of every guideline before it can be used. However, it emphasises the need for very careful control of the quality of the development, dissemination, and implementation of guidelines.

Standards by which the development of guidelines may be measured have been set by several people and institutions.[7-11] Most people agree that if clinicians are to accept guidelines, then they must have confidence in their validity, and therefore the methods of production must be transparent. The user must be able to check up on their contents if he or she should think it necessary. Furthermore, they agree that evidence based guidelines are likely to produce the highest quality of advice. Guideline appraisal instruments have, however, proved difficult to apply, partly because of the poor quality of documentation on the development process used in most guidelines.[12 13] The authors of the paper in this issue of *Quality in Health Care* have taken a much simpler approach to assessment of guidelines, and although the measures of quality used are distant proxies for their likely effect on outcome, they are nevertheless illuminating. They provide disturbing information on the quality of available guidelines, showing that few even contain a list of references, and that even those that do seem to be based largely on unsystematic reviews of the literature.

The task we now face is to improve the quality of our own quality improvement methods, and to show their quality to potential users. The work of Varonen and Makela[6] provides suggestions as to how this might be done. The quality of national guidelines seemed greater than that of local or regional products. This is perhaps not surprising, but is nevertheless important. Development of guidelines requires considerable skill and resources perhaps beyond those available to most local or regional bodies. For many countries these necessary prerequisites may only be available at a national level.

We must also consider the dissemination and implementation of guidelines. Varonen *et al* describe difficulties in identifying guidelines, and point out that it was considerably easier to identify national guidelines than local ones. Although guidelines are not disseminated with the needs of researchers in mind, these difficulties provide circumstantial evidence that it may also be difficult for clinicians to identify relevant guidelines when they are required. Again, it seems likely that the resources and established communication networks of national bodies would provide clinicians with easier access to guidelines.

Although it is widely thought that local guidelines are more likely to be taken up than those produced further away, the evidence for this is far from conclusive. Although it is likely that involvement of users in the development process eases implementation, at least one trial suggests the opposite, and there is little evidence that local production itself improves uptake.[1] The issues affecting uptake of recommendations in guidelines are likely to be far more complex than a simple matter of site of production, and seem likely to be related to both the apparent validity of the guidelines, and to how easy it is for clinicians to obtain and to use them.

Finally, we should consider the fact that variation in local conditions may affect both the strength of evidence required before it is prudent to act, and the specifics of how such action is best organised. National guidelines may therefore require adaptation for local use. This adaptation should reflect the strength of the evidence, and recognition that it may be necessary should further encourage the developers of evidence based guidelines to specify the strength of the evidence from which their recommendations are drawn. This grading of recommendations would greatly facilitate later local adaptation by allowing identification of areas where there is room for differing interpretations. Revisions of nationally produced guidelines at local level would require fewer resources and generate fewer errors than a system that requires guidelines to be developed from scratch in each local area, but would allow the positive features of local guidelines to be preserved.

The solution to the problem of proliferating low quality guidelines is unlikely to be to ridicule their developers, who are doubtless doing their best, but to offer them and the clinicians they are trying to support something better, and something that is obviously better. It seems increasingly likely that the quality and accessibility of guidelines is maximised by coordinated national programmes, with later local adaptation of guidelines as required. The need for respected national bodies to accept responsibility for the development, dissemination, and implementation of guidelines is urgent.

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